

**TERRITORIAL POLITICS AND THE DEVELOPMENT OF HEALTH CARE IN  
CANADA, 1960-1984**

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The development of national public medical care insurance in Canada is often viewed as the result of a relatively natural process of evolution flowing out of earlier federal and provincial policy innovations such as universal hospital care insurance at the federal level and medical care insurance in Saskatchewan. However, the development and consolidation of national universal medical care insurance in the period from the mid-1960s to the mid-1980s was not a linear progression from earlier federal and provincial programs of public insurance (as one might expect in a highly path dependent process) but, rather, was highly tenuous and contingent. The successful implementation of a federal program of universal public insurance for medical care in Canada occurred in spite of a number of conditions auguring against its adoption. In this tenuous and contingent process of development in which the particular outcomes which emerged were strongly conditioned by the sequence of development, the conjuncture at key points between the politics of health care and politics of territorial integration played an important role contributing to the emergence of universal medical care insurance. Powerful political currents – especially those developing in Québec – provided a central dynamic in favour of the development of a national system of medical care insurance designed to touch the lives of all Canadians regardless of where they lived.

The paper examines the conjuncture between the politics of public health insurance and the politics of territorial integration over two broad phases of the development of public medical care insurance in Canada: its introduction in the period from 1960 to the adoption of an eligible medical care insurance program by all provinces in 1971 and its consolidation in the period between 1971 and the adoption of the Canada Health Act (CHA) in 1984. In considering the former, the paper outlines existing arguments implying that the introduction of a federal program of public medical care insurance was a natural extension of innovations at the provincial level which are, in turn, largely explained by the effects of the institution of federalism. It argues that the effects of provincial innovations, especially the development of a program of medical care insurance in Saskatchewan, were much more ambiguous in their implications for future federal reform. The paper then argues that the conjuncture between the politics of territorial integration and public health insurance, the federal intention to use public medical care insurance as a powerful tool of territorial integration, was an important

driver of federal reforms. In examining the period of consolidation of universal public health insurance, the paper argues that, again, a conjuncture between the politics of territorial integration and the politics of public health insurance was a key element in driving federal reforms.

### **THE INTRODUCTION OF A FEDERAL PROGRAM FOR MEDICAL CARE INSURANCE IN CANADA, 1960-1971**

National medical care insurance in Canada has often been treated as having evolved out of a set of previously existing conditions – most notably, the development of public medical insurance at the provincial level and, secondly, the development of a federal program for cost-sharing hospital insurance. These developments are, in turn, typically explained as resulting from Canada’s particular institutional configuration – especially the impact of federalism. However, this section argues that the political conditions, following the advent of provincial reforms, were not very favourable to the development of a federal program of public physician-care insurance. Nevertheless, the politics of territorial integration, the perception on the part of federal policymakers that public medical care insurance could be used as a powerful tool of territorial integration, provided an important dynamic driving reform.

#### **National Medical Care Insurance as a Linear Progression**

Provincial innovations in public health insurance have been argued to have been central to federal reforms. Hacker argues that “the provinces proved to be a crucial incubator of policy activism” and “provincial efforts later paved the way for national legislation.” (1998: 72) Tuohy also emphasizes the degree to which federal legislation is seen to have flowed out of provincial innovations in arguing that the major difference between the development of public health insurance in Canada and the United States was policy innovation at the provincial level: “The two countries differed in one important respect. Whereas Canadian provincial governments became the loci of experimentation with governmental hospital insurance, American state governments did not.” (1999: 47)

Provincial reforms are argued to have contributed to federal reform in a number of ways. First, they acted as “demonstration projects” both for other provinces as well as

federal policymakers. (Hacker, 1998: 96) Tuohy carefully points out that medical care insurance in Saskatchewan had both negative and positive demonstration effects; however, the latter, the degree to which the Saskatchewan program demonstrated the feasibility of universal public medical care insurance, in her analysis, appears to have outweighed the former. (Tuohy, 1999: 53) In addition, these innovations “served as test cases that defused conflict with opponents of the reformers, particularly doctors.” (Maioni, 1998: 160) Finally, they encouraged provincial leaders to demand federal funding for provincially-provided programs. (Hacker, 1998: 96)

A second line of reasoning which ties the development of public medical care insurance back to earlier policy development is the argument that that the federal program of hospital insurance created the expectation that medical care insurance would naturally follow. Medical care insurance “...had become a natural, normal expectation” that awaited only the right time for implementation. (Taylor, 1990: 143) In a similar vein, Maioni argues that the development of medical care insurance represented the “consolidation of existing federal-provincial arrangements based on universal health insurance principles. The debate centered not on providing health insurance to certain groups [as in the United States] but on the extension of benefits beyond hospital insurance to cover the costs of medical care.” (Maioni, 1998: 119) In turn, the development of federal hospital care insurance is also often viewed as the logical extension of provincial hospital care insurance schemes – especially that of Saskatchewan which had been developed more than a decade earlier.

Electoral considerations are typically central in these explanations of federal action on the medical care insurance front. The Liberals faced an emerging threat from the left by New Democratic Party which, having been formed out of the CCF in 1962 and having Tommy Douglas as its leader, could claim the adoption of medical care insurance in Saskatchewan as its own. As a result, the governing Liberals faced pressure in the House of Commons from the NDP to develop a national health insurance system based on the Saskatchewan model.<sup>1</sup> (Maioni, 1998: 130; Hacker, 1998: 103, 104) The NDP

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<sup>1</sup> Hacker argues that while pressure for a national program came from the demands of the provinces, the “strongest pressures for action came from the exigencies of the Liberal Party’s minority status in parliament.” (Hacker, 1998: 103, 104)

had made medicare the central plank of its election platform in both 1962 and 1963. In response, public insurance for medical care was a central plank in the Liberal platforms of 1962, 1963 and 1965. (Gordon, 224; La Marsh, 122; Newman, 412) Following the election of 1965, it is argued that the governing Liberals then felt compelled to introduce the program in light of these electoral commitments, or, alternatively, were forced to do by virtue of their need to maintain the support of the NDP.<sup>2</sup> Underpinning this line of reasoning is a broader argument regarding the key role of the configuration of Canadian political institutions in encouraging the development of third parties at the provincial level which, in turn, contributed to the development of the NDP as a powerful electoral force at the national level.

These arguments which focus on earlier developments at the provincial level typically tie the development of public medical care insurance in Canada back to the configuration of political institutions. For example, because federal innovations followed from provincial innovations, the central question becomes “[w]hy and how did the provinces take the lead in enacting first hospital insurance and then comprehensive medical insurance?” (Hacker, 1998: 100) The answer to this question, for Hacker, is institutional. First, federalism created opportunities for provincial parties supportive of reform to gain power and, as a result, “...Canadian federalism fostered the development of provincial programs that could serve as examples to neighbouring provinces and eventually form the basis for national legislation.” (Hacker, 1998: 99). Secondly, federal grants equalized the fiscal capacity of provinces, provided the prospect that federal transfers would become available for health programs, and, in provinces which already had eligible programs as cost-sharing became available, freed up funds for further policy entrepreneurship.<sup>3</sup> (Hacker, 1998: 101) Underpinning these explanations is a focus on political institutions and, especially, the impacts of Canadian federalism. However, as

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<sup>2</sup> Regarding the former interpretation, see Newman, 412 and La Marsh, 86. Regarding the latter, see Hacker, 1998: 103 and Maioni, 1998: 162.

<sup>3</sup> For Tuohy, the shifting of the locus of reform efforts from the federal level to the provincial level in Canada (following the failure of federal health insurance reforms in 1945) appears to have been sufficiently natural that what requires explanation is why a similar shift did not take place in the United States – an outcome which she attributes to strategic calculation on the part of reformers.

argued below, the dynamics driving federal reform were not just generated by Canada's institutions configuration but were rooted in the structure of Canadian society.

### **The Political Context of Federal Medical Care Insurance Proposals – Medical Care in Saskatchewan and Negative Feedback**

While it is often argued that the development of public medical care insurance in Saskatchewan set in motion positive feedback dynamics that would create pressure for federal reforms, the political context for federal medical care insurance proposals in the wake of the developments in Saskatchewan was not particularly propitious. Although universal public medical care insurance had been successfully implemented in Saskatchewan, this development, in itself, triggered a number of negative feedback dynamics auguring against the adoption of a similar program at the federal level. First, it generated even more serious resistance by the Canada Medical Association (CMA) to public physician-care insurance at the national level than had existed prior to the Saskatchewan experiment. Secondly, it contributed to the adoption of alternative health insurance plans in other provinces. Finally, it created serious concern at the federal level about the degree of resistance which a federal program might encounter.

One of the crucial effects of the adoption of medical services insurance in Saskatchewan was to steel the resolve of the CMA in its opposition to compulsory public insurance for physician services. Organized medicine in Canada viewed the development of public medical care insurance in Saskatchewan as a "serious breach." (Taylor, 1990: 129) In response to the developments in Saskatchewan, the President of the CMA made a "...ringing call to the profession to reinforce the private governmental structure it had created to prevent any further breach in the system. And it made very clear its fear of, and determination to exclude, any other influence in the arrangements the profession controlled." (Taylor, 1990: 130) As the CMA was campaigning vigorously against medical care insurance at the national level, it issued constant warnings that "...the introduction of medical care insurance, which they pejoratively referred to as socialized medicine, would lead to an exodus of doctors from the country." (Taylor, 1990: 26)

Furthermore, in the wake of Saskatchewan's adoption of medicare, Alberta, Ontario and British Columbia began introducing programs designed to reinforce

voluntary insurance and physician-controlled prepayment programs -- a major breakthrough for the CMA and Canadian Health Insurance Association (CHIA).<sup>4</sup> (Taylor, 1990: 133) Proposals in Alberta went furthest in this regard. Alberta passed legislation for income-based subsidization of private insurance coverage in early 1963. The program was a direct response to the adoption of public health insurance in Saskatchewan and the Alberta premier, Ernest Manning, believed that the new program "...would give Canadians a program they could set alongside 'the socialistic type of program' in Saskatchewan." (Taylor, 1990: 133) Indicative of the philosophical predisposition of the Alberta government, in his testimony to the Hall Commission, the Alberta Minister of Health stated unequivocally that "...his government was opposed to any program of state medical care 'which removes all direct individual financial responsibility; so-called socialized health and medical services are incompatible with the rights and responsibilities inherent in a free and democratic society.'" (Taylor, 1987: 338) The Alberta program became the proto-type for proponents of an alternative to universal compulsory public insurance and had the strong support of the CMA and CHIA who believed that it needed to succeed in order to stem popular demand for public insurance based on the Saskatchewan model.

Other alternatives to universal public insurance coverage were developing in Ontario and British Columbia. Both provinces took a different tack from the Alberta plan by directly providing individual insurance which would be subsidized on an income-tested basis while leaving group insurance to the private insurance carriers.<sup>5</sup> (Taylor,

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<sup>4</sup> This interpretation contrasts sharply with that of Hacker who argues that "Provincial governments in British Columbia, Alberta and Ontario moved almost immediately to consider the plans that followed the Saskatchewan precedent." (1998: 100) Hacker's interpretation of the British Columbia, Alberta and Ontario plans as being highly consistent with the Saskatchewan plan is a key element in his argument that federal reform was the result of a relatively linear progression stemming from adoption of medical care insurance in Saskatchewan.

<sup>5</sup> The Ontario bill was introduced in 1963 but, instead of being passed, was referred to an independent commission. After extensive public hearings, the commission recommended amendments which would include coverage for the indigent (in addition to providing subsidies for low-income earners.) The plan would finally be passed in 1966 as the Ontario Medical Services Insurance Plan (OMSIP). A similar plan had also been adopted in British Columbia with the creation of the British Columbia Medical Plan (BCMP) in 1965.

1990: 134) Despite the differences between the Alberta approach (subsidization of privately-provided insurance for low-income persons) and the Ontario/BC approach (government provision of individual insurance which would be subsidized for low-income persons), none of these three provincial initiatives were propitious for further development of universal public physician care in Canada: “Three of Canada’s most powerful provinces had now acted in such a way as to leave the majority of the population who could afford voluntary insurance to the private sector, while governments paid part or all of the costs for the ‘poor risks.’” (Taylor, 1990: 134)

Québec would also fall into line with these other provinces before the federal medicare program came into effect. The provincial Liberals appeared to be considering more ambitious plans for medical care insurance reform; however, they were defeated in 1966 by the more conservative Union Nationale and the policy position of the Québec government shifted to explicit support for subsidizing health insurance for low-income persons. Thus, the four largest Canadian provinces were committed to public plans that would provide or subsidize physician care insurance to those with low-incomes while leaving the rest of the population to voluntary insurance for physician care.

The development of these alternative proposals demonstrates the degree to which universal public insurance care was not assumed to be the necessary complement to or natural extension of universal hospital insurance. Certainly, the governments of four largest provinces in Canada did not see this as necessary, natural, or even desirable and had posed a credible alternative. In fact, at points, there appeared to be hints that reinforcing voluntary programs and subsidizing coverage for low-income persons might be the type of solution that the federal government would itself consider. Writing to the Cabinet to solicit input on the Throne Speech for 1965, Prime Minister Pearson noted: “I do not think we can plan to take that [medical care insurance] on, at least in any comprehensive way in 1965. *But we do need to make some plans for dealing with the greatest needs in this area.*” (Taylor, 1987: 363, italics mine)

Finally, the Saskatchewan experience generated considerable concern among federal policymakers. The difficulty of implementing medical care insurance in Saskatchewan demonstrated just how politically risky the venture would be for a minority Liberal government at the federal level. Certainly, the Saskatchewan doctors’ strike

removed any perception at the federal level that medical care insurance would be a natural evolution from hospital care insurance.<sup>6</sup> Federal policymakers were acutely aware that there was “a hell of lot of opposition” to the plan in Saskatchewan. In light of the developments in Saskatchewan, the federal decision to proceed would have to be made on the assumption that an expansion of public health insurance would be campaigned against vigorously -- which it was, especially by the insurance industry which argued that the federal proposals would “ruin the nation”.<sup>7</sup>

The omens for the successful achievement of a national plan “now were increasingly dark.” (Taylor, 1990: 144) In the view of the CMA, “the odds in favor of the market-economy approach...were shifting most favorably.” (Taylor, 1990: 140) Encouraged by these outcomes, the CMA was stepping up its publicity campaign against universal compulsory public health insurance as well as directly lobbying at the highest political levels.<sup>8</sup> Furthermore, public support of compulsory public physician-care insurance was weak. In a public opinion poll conducted in the fall of 1965 as the government was preparing to introduce legislation, support for a voluntary plan (52%) outstripped support for a compulsory plan (41%) by a significant margin.<sup>9</sup> Nevertheless, the Liberal minority government elected in 1963 and re-elected as a minority again in 1965 would persevere in pursuing a national plan. The provinces, on the whole, were recalcitrant. At the annual Provincial Premiers Conference, “[s]trident were the tones, so angry the voices, and so vehement the opposition that one journalist summed up, ‘The federal government’s proposed legislation lies torn, tattered, and politically rejected.’” (Taylor, 1990: 149) When the federal government announced

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<sup>6</sup> Interview with Tom Kent, Principal Assistant to Prime Minister Lester B. Pearson, April 2005.

<sup>7</sup> Ibid.

<sup>8</sup> The CMA executive met with the Minister of Health and Prime Minister in June 1965. (Taylor, 1990: 141)

<sup>9</sup> When asked about the apparent support in public opinion polling for a voluntary plan rather than compulsory plan, Tom Kent emphasized that senior policymakers did not put much stock in public opinion polls – believing that the answers were largely shaped by the way the questions were asked. They believed that, in the last analysis, a straight public plan was “what people would vote for.” As Kent points out, the real evidence of public support for the proposal was that it was voted for unanimously in the House of Commons. Interview with Tom Kent.

its medical care insurance proposals in 1965, Premier of Alberta Ernest Manning commented acerbically, “I suppose we’ll be proposing grocery-care next.”<sup>10</sup>

However, the federal government would eventually push through a conditional cost-sharing program for public medical care insurance. Of course, various compromises were made. For example, the medicare program would have “principles” rather than “conditions”, a semantic measure intended to make the plan more palatable to the provinces. These principles, later to become enshrined in the Canada Health Act (CHA), were portability, public administration, comprehensiveness, universality, and accessibility.<sup>11</sup>

From the outset, the Québec government would flatly refuse to participate in any federal scheme in an area of primarily provincial jurisdiction. The Premier of Québec Jean Lesage argued that Québec would bring in a plan of medical care insurance but that “When our plan is introduced, it will be operated outside any joint Federal-Provincial program in line with our general policy of opting out of all areas within our competence...”<sup>12</sup> (quoted in Taylor, 1990: 147) The Québec position had been and remained clear: its overriding objectives were complete provincial autonomy in all areas of provincial jurisdiction and securing the financial capacity to fund programs in these areas independently of conditional federal transfers. However, this provincial recalcitrance was overcome by a brilliant federal maneuver of dubious constitutional legitimacy – certainly breaking the spirit, if not the letter, of the Canadian constitution. In the fall of 1968, the federal finance minister announced an increase of two percent in federal income tax. Although it was formally called the social development tax (as it would have been unconstitutional for the federal government to levy a health care tax), the tax was clearly intended to finance federal contributions to health insurance. As a federal tax, taxpayers in all provinces would be, in essence, paying for medical care

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<sup>10</sup> Ibid.

<sup>11</sup> The federal contribution would match total spending by all provinces with this total amount being divided among provinces on a per capita basis.

<sup>12</sup> Rather than calling for federal financial aid for health care (or any other specific program area), the Québec government called for the federal government to “...make it easier for provinces to exercise their constitutional powers, for example, by rectifying the present system of sharing revenue sources in Canada.” (Lesage quoted in Taylor, 1990: 147) This continues to be the position of the Québec government in 2005.

insurance regardless of whether or not their province had a program eligible for federal cost-sharing. This created significant political pressure on provincial governments to acquiesce to the program. (Taylor, 1987: 392) As a result, all provinces, even those which were less than enthusiastic about the federal plan such as Québec, quickly developed programs eligible for federal cost-sharing. (See Table 1.)

### **The Politics of Public Health Insurance and the Politics of Territorial Integration**

While the factors outlined above undoubtedly made an important contribution in shaping the development of public medical care insurance reform, the conjuncture of the politics of public health insurance and the politics of territorial integration played a key role in driving that development.

#### ***The Politics of Territorial Integration in Canada***

Territorial integration has been and continues to be *the* central issue of Canadian statecraft. Canadian political development has been deeply marked by the interplay of powerful territorially-defined dynamics resulting from cultural/linguistic and economic tensions in the Canadian federation. Furthermore, territorially-based axes of political conflict have been reinforced by existing institutions – especially the operation of Canadian federalism: “Federal institutions reflect and give added life to territorial politics in Canada” because they are “particularly responsive” to “social and economic interests that can be defined on territorial terms” and exhibit an “inbuilt sensitivity to regional claims.” (Banting, 1995: 273) As a result, “Canada is a rich case study in the subtle interplay between territorial politics and the welfare state. The combination of federal institutions, linguistic and cultural pluralism, and regional conflicts has important implications for the design of Canadian social programs.” (Banting, 1995: 271) Dynamics generated by the politics of territorial integration significantly colored policy debates in the postwar period and, coincident with debates over public medical care insurance, their full weight came to bear on Canadian politics in the late 1950s and early 1960s.

Social policies have long been recognized as important mechanisms of social integration. In societies where the primary social cleavages were along class lines, social

policies were central to mediating class divisions. (Banting, 1995: 270) Similarly, in societies marked by territorially based axes of political conflict, social policies also play a central role in the politics of territorial integration. In the Canadian context, social policy has played a central role in the politics of territorial integration:

National social programs create a network of intimate relations between citizens and the central government throughout the country, helping to define the boundaries of the national political community and enhancing the legitimacy of the state. In countries whose territorial integrity is not questioned, this integrative role of social policy goes largely unnoticed. In countries that are deeply divided along regional lines, however, the territorial role of the welfare state is highly salient, and much depends on the locus of program control. Social programs controlled by the central government can become instruments of nation building, helping to mediate regional tensions and strengthen the state against centrifugal forces rooted in territorial politics. Alternatively, social programs designed and controlled at the regional level can become instruments for strengthening regional cultures and enhancing the significance of local communities in the lives of citizens, thereby reinforcing differentiation and centrifugal tendencies at the national level. (Banting, 1995: 270)

Thus, it is not surprising that the politics of social policy in Canada have been swept up in the political struggles generated by these territorial challenges. (Banting, 1995: 272)

Of central importance in the Canadian context has been the emergence of a dynamic that Banting terms competitive state-building in which different levels of government compete vigorously to occupy political space:

Governments in Canada have long recognized the potential of social programs as instruments of statecraft, to be harnessed to nation-building agendas. This can be seen most clearly in the protracted struggle between the federal government and the province of Quebec for the commanding position in the politics of welfare during the second half of the 1960s and 1970s. The intensity of these disputes can be understood only by appreciating the extent to which the two governments vied to retain the loyalty of Quebecers and to protect and enhance their institutional power. (Banting, 1995: 284)

At the same time, the reliance of poorer provinces on interregional redistribution through the federal government has generated powerful institutional support for an expansive role for the federal government including national social policy. (Banting, 1995: 272)

Certainly, the contemporary role of health care in the politics of territorial integration is clear. The politics of health care are now aptly described as an increasingly sophisticated “political football game” which is “played by professional state-builders in

a charged atmosphere in which the political and financial stakes are considerably higher than they were in the past.” (Maioni, 2001: 87) As Maioni notes, all players “...recognize the extent to which disputes about health care involve struggles over economic and political space in the federation.” (Maioni, 2001: 88) The federal role in health care is imbued with considerable symbolic significance:

...the federal government can claim to have ‘nationalized’ health care and promoted ‘equal citizenship’ among Canadians and guaranteed health benefits to all. In debates about provincial autonomy, national unity, or constitutional renewal, this is of enormous significance: the federal government has no constitutional role in health care but can claim to defend the ‘integrity’ of the popular features of the ‘Canadian’ health care model. (Maioni, 2001: 100)

Despite the centrality of these territorial dynamics to the Canadian polity and in the current politics of health care, the politics of territorial integration have not been central to explanations of the historical development of the health care system in Canada.

#### *The Politics of Territorial Integration and the Politics of Public Health Insurance*

The politics of public health insurance would become bound up in the politics of territorial integration. The context from which medical care insurance emerged was marked by powerful tensions between the nation-building aspirations of the federal government and the government in Québec. The clash between these different visions had been on-going with many specific issues being resolved in favour of the latter. By the time that the federal government was proposing a federal program for medical care insurance, the Province of Québec had already opted out of federal post-secondary education funding (receiving an abatement of corporate taxes in lieu of direct grants to universities), foregone benefits to its citizens under the Unemployment Insurance program, indicated that it would be opting out of federal-provincial cost-sharing for hospital insurance, and was in the midst of negotiations to construct its own pension system, the Québec Pension Plan – parallel to, but distinct from, the Canadian Pension Plan (CPP). Ottawa had also acknowledged the right of provinces to “contract out” of existing shared-cost programs receiving compensation for well-established joint

programs through tax abatement rather than federal cash transfers.<sup>13</sup> To varying degrees, some instances of Québec's exercise of provincial autonomy were largely symbolic. For example, Québec had promised not to alter existing services provided under federal-provincial cost-sharing arrangements from which it proposed to opt out. However, in politics – especially territorial, nationalist, and linguistic politics – symbolism is key.<sup>14</sup> Liberal ministers began to feel the pressure of this situation. As Judy La Marsh, Minister of Health and Welfare would note: “The public felt that we should heed no more of Québec's repeated attacks upon the citadel of a strong federal government.” La Marsh and other ministers felt the situation in regards to Québec was increasingly “insupportable.” (La Marsh, 1969: 123)

Given this context, it was clear that public medical care insurance was not a policy area which the federal government would willingly cede:

...these “national objectives” of Quebec ran counter to four federal government objectives: (1) The necessity of maintaining a direct federal “presence” with Canadian citizens, which could not be limited simply to imposing federal taxes to subsidize provincially-administered programs for which provincial governments presumably received the political credit; (2) The desirability – indeed, in Ottawa's view, the necessity – of maintaining national standards and portability of program rights even in programs such as hospital insurance in which a “contracting out” privilege might be granted after the program had been in operation for some time; (3) The retention of strategic fiscal control of the economy, an objective that would be weakened by outright transfer to the provinces of large spending programs and their accompanying income tax “points”; (4) And, finally, as a Liberal government – fulfillment of a commitment made by the party in 1919 and constantly reiterated thereafter to develop a program of *national* health insurance. (Taylor, 1987: 381)

In a context in which provinces could opt out of *established* programs, a new cost-sharing program offered unique opportunities for a strong federal role. Constitutional questions

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<sup>13</sup> Federal conditional grants had first been challenged by Québec in 1960. The Liberal Party, while in parliamentary opposition, had adopted the policy of allowing provincial ‘opting out’ from established programs with compensation. After the Liberals returned to power in 1963 as a minority government, the change was agreed to at a federal-conference. Tax abatements differ significantly from cash transfers in that the only way for the federal government to reclaim tax room ceded to a province is to raise its own tax rates – a move which is highly politically unpopular. Thus, the effect of tax abatements is to make transfers essentially both unconditional and permanent.

<sup>14</sup> The importance of symbolic politics is compelling argued and illustrated in Edelman's classic work, *The Symbolic Uses of Politics*.

aside, the relevant political question was whether public opinion in favour of universal medical care insurance was sufficiently strong in Québec, that the federal government could put pressure on the provincial government which it could not resist. Federal policymakers were well aware that universal public medical care insurance had as much popular appeal within Québec as anywhere else.<sup>15</sup>

The issue of territorial integration was among the top priorities of the cabinet in this period.<sup>16</sup> Certainly, as Maioni notes, "...the Prime Minister considered social programs part of a strategy to strengthen the presence of the federal government and encourage 'nation' building across Canada." (Maioni, 1998: 132) Viewing social programs as instruments of nation-building was, in the words of Tom Kent, Principal Assistant to Prime Minister Pearson and the key architect of Canadian social policy at the time, "a perfect expression of the spirit in which we saw things." In the view of federal policymakers, the problem of the Canadian federation was not vertical fiscal imbalance but political imbalance by which the most important functions of government, in the eyes of Canadian citizens, are matters of provincial jurisdiction.<sup>17</sup> As Kent argues, policymakers felt it imperative that "Canada had to become a social union as well as an economic union."<sup>18</sup> Although there was dissent within the party, this point of view was very powerful in shaping the program on which the Pearson government came to office reflecting the outlook both of Prime Minister Pearson and his advisors as well as the grassroots of the Liberal Party. The main overarching concern of the Liberal government upon its election in 1963 was "positive Canadianism" which included an emphasis on cooperative federalism. Additional broad concerns were the economy and social policy including, most notably, pensions and medical care insurance.

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<sup>15</sup> Interview with Tom Kent.

<sup>16</sup> In outlining the dynamics driving federal medical care insurance reform, Taylor argues that "the main thrust came from the handful of new progressive leaders in the cabinet[.]" (Taylor, 1990: 143) If the federal approach was primarily the result of new, progressive leaders in cabinet, the question becomes what they saw as the most crucial issues to be addressed and what they hoped to achieve.

<sup>17</sup> Vertical fiscal imbalance refers to the situation by which provincial jurisdictional responsibilities are significantly greater than provincial powers of taxation.

<sup>18</sup> In Kent's view, this would required asymmetry with regard to Québec.

The initial proposals considered at this time were for a straight federal program for medical care insurance. In an effort to revitalize thinking among small-l liberals in Canada, a conference had been held in Kingston, Ontario in 1960. The main policy paper was prepared by Tom Kent and the top priority in Kent's paper was medical care insurance. The recommendations of the Kingston Conference worked themselves into policy resolutions presented to a Liberal party rally in January 1961. Medical care insurance became the most important issue of that meeting with the party passing a resolution in favor of the extension of medical care insurance according to a very specific plan: the federal government would pay medical care costs for individuals directly.<sup>19</sup> A central rationale for this style of program was that "[t]he glue of Canada needed to be improved by nationwide social policy."<sup>20</sup> In response to constraints on a straight federal approach, Kent himself would, on the election of the Liberals, begin promoting a more limited program which he referred to as Kiddie Care which proposed a straight federal program of universal health insurance for children.<sup>21</sup>

The political prospects for a straight federal program of either a universal or categorical (e.g. limited to children) variety would be radically transformed by a number of factors. The first was the Report of the Royal Commission on Health Services (Hall Commission) in 1964. The Hall Commission provided, in large part, the philosophical rationale for the expansion of universal public insurance to medical care.<sup>22</sup> The Hall Commission, reflecting its own concern with issues of territorial integration, recommended a "Health Charter" of which the essence was as follows: "The achievement of the highest possible health standards for all our people must become a primary objective of national policy and *a cohesive factor contributing to national unity*... The objective can best be achieved through a comprehensive, universal Health Services

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<sup>19</sup> In addition, the benefits would be taxable in order to make the overall system more progressive. Interview with Tom Kent.

<sup>20</sup> Ibid.

<sup>21</sup> At the same time in the United States, Kennedy administration policy advisers also were discussing the idea of Kiddie Care which was seen to be the natural complement of Medicare.

<sup>22</sup> The Hall Commission was appointed in mid-1961 and reported three years later in mid-1964.

Program for the Canadian people.”<sup>23</sup> (Taylor, 1990: 135, italics mine) However, the central recommendation of the report was to achieve this coverage through a system of federal-provincial cost-sharing. The central rationale was that it was imperative to have all programs for personal health services lodged at the same level of government in order that they be integrated. For federal policymakers, this recommendation made “the politics of a federal plan much more difficult.” The Hall Commission was widely seen as having considerable legitimacy not the least of which stemmed from the fact that, having been appointed by a Conservative government and reporting under Liberal government, it was perceived as a bipartisan committee.<sup>24</sup>

Secondly, while progressive forces were able to take control of the Liberal Party when it was in opposition, there was a right-wing revival inside the party upon its re-election in 1962. This revival took place under the leadership of Mitchell Sharp who would become Minister of Finance in 1965. Sharp was opposed to expanding public medical care insurance and felt that, if it had to be done, it was best to limit federal involvement to a cost-sharing basis.<sup>25</sup>

Finally, even though the Liberal party was firmly committed to moving forward on medical care insurance *before* the Saskatchewan plan was implemented, this development was critical in prompting a shift away from a straight federal program.<sup>26</sup> Displacing an existing provincial program would be politically much more difficult in terms of federal-provincial relations than the alternative of simply sharing the costs for eligible provincial programs. Furthermore, the reforms in Saskatchewan had prompted the appointment of the Hall Commission which, in turn, significantly reinforced a federal-provincial cost-shared scheme. The logic that all personal health services should

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<sup>23</sup> The report recommended public insurance coverage of a comprehensive range of services including medical services; dental services for children, expectant mothers, and public assistance recipients; prescription drug services; optical services for children and public assistance recipients; prosthetic services; and home care services.

<sup>24</sup> Interview with Tom Kent.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid..

be lodged at one level of government was compelling but not determinative.<sup>27</sup> It is interesting to speculate as to whether, had the Saskatchewan reform not been undertaken, the federal government might have proceeded with a straight federal program of physician care insurance (whether universal or categorical such as a program limited to children).

Electoral considerations would figure prominently in the final formulation of the federal proposals. By 1965, the government was “frayed” by pension and flag debates and felt that the root of the problem was its status as a minority government.<sup>28</sup> As pressure within the government to go to an election built, there was also a strong belief that the party needed a well-defined medical care insurance proposal to successfully wage an election campaign. In light of the various factors outlined above, the proposal that would emerge would be for federal cost-sharing of provincial programs of medical care insurance. The nation-building intent behind such programs would, however, remain implicit. The Liberal electoral strategy can be summed up in the words of senior Liberal strategist, Walter Gordon: “We should appeal for a strong federal government to build a new Canada. We should request a mandate to proceed with such programs as Medicare. ...it would be a mistake to emphasize the Québec problem, not because we do not consider it the number-one domestic issue but because people in English-speaking Canada do not like being reminded of it.” (Gordon, 1977: 224)

As Kent outlines, the role of Québec was “absolutely crucial” to the endorsement of medical care insurance by the federal government: “There would have been no Canadian welfare state if pre-1960 Québec politics had continued.”<sup>29</sup> Changes in Québec were “absolutely essential to moving ahead.” The new Lésage government was as keen on social policy as was the federal Liberal government. Federal officials perceived the Pearson government and Lésage government of Québec as having the same

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<sup>27</sup> This logic was offered by Prime Minister Martin in mid-2004 as a rationale for why the federal government would not accept the provincial offer for the federal government to move ahead with a straight federal program of public drug coverage.

<sup>28</sup> Interview with Tom Kent.

<sup>29</sup> According to Kent, far more than people appreciated, there was a real alliance between the Lésage and Pearson governments. According to Peter C. Newman, “Pearson’s main policy preoccupation was his attempt to sponsor some kind of accommodation between Québec and the rest of the country.” (Newman, 1968: 45)

broad objectives in health care and federal officials believed that a federal cost-sharing program could be made politically acceptable even in light of Québec nationalism. In so doing, federal officials conceived cost-sharing for medical care as being significantly different from cost-sharing for hospital care with the former being based on broad principles rather than federal monitoring of a detailed program. Thus, federal policymakers fashioned a proposal that would prove impossible for the Liberal government in Québec to resist.

As soon as the federal government announced its intentions to initiate a federal cost-sharing program for medical care insurance, the Québec government declared that it intended to bring in its own program outside of the rubric of any federal shared-cost plan. (Taylor, 1987: 356) To this point, there had been very little government action in Québec to support this claim. Rather, it was after the conference that the Québec premier “set events in motion” announcing that health insurance would be introduced the following year and establishing a committee to study the issue. (Taylor, 1987: 386, 392) The two governments now were jockeying to be the first to occupy the political space created by the issue of medical care insurance.

Although the Liberal government in Québec was replaced by the Union Nationale government in mid-1966, the Québec government continued to insist that it had full jurisdictional competence over health care and demand that the federal government should cede further tax room and return the tax capacity to Québec which it required to exercise this competence. (Taylor, 1987: 386) However, despite the fact that the influential Castonguay committee (which had been appointed by the Québec Liberals) recommended the establishment of a comprehensive, universal health insurance program, the Union Nationale publicly committed itself to a policy of subsidizing health insurance provided to those with low-income through existing agencies. (Taylor, 1987: 389, 390)

Two factors would combine to make this policy position futile. First, the structure of the ‘health insurance tax’ meant that if the Québec government were to refuse to go along with the federal plan, Québec citizens would be taxed and the proceeds transferred to other provinces. Of course, the Québec government (and some Québec Members of Parliament) vociferously protested; however, the federal government, from the outset, refused to budge. As the program was implemented and Québec stayed out,

federal intransigence was reinforced by the election results of 1968: "...the federal government with its recently acquired large majority in the Commons, and especially its success in Quebec, was in no mood to compromise." (Taylor, 1987: 392) Secondly, the position of the Québec government ran against strong public support for medicare inside the province of Québec – a factor that the federal government was counting on. Support for the federal medicare program in Québec proved to be higher than in any other region in Canada by a considerable margin. (See Table 8.2) Given the immense pressure on the Québec provincial government generated by federal maneuvering, it seemed largely a foregone conclusion that Québec would eventually join the program despite its efforts to resist.<sup>30</sup> (Taylor, 1990:150) Despite its aspirations to exercise full provincial autonomy, the Québec government could not resist the federal offer even in the face of federally-stipulated "national principles."

Marking a crucial difference with plans in the other provinces, when Québec responded to federal pressure to adopt a compulsory universal insurance program for medical care, it would go beyond the federal requirements and also ban extra-billing in the province. (Maioni, 1998: 133) This was the result of a serious confrontation with powerful political forces within its own province. Ultimately, the Québec specialists would go on strike (though emergency specialist services were maintained) and finally be legislated back to work. However, the provincial government would prevail and extra-billing would be effectively banned.

## **THE CONSOLIDATION OF PUBLIC HEALTH INSURANCE IN CANADA, 1971-1986**

Important changes were to take place in the federal program for cost-sharing hospital and medical care insurance in Canada in the decade and a half following the implementation of a complete set of provincial medical care insurance programs in 1971.

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<sup>30</sup> Premier Bertrand was resigned: "Ottawa has placed us in a position where we might be one of the last provinces to sign...Either Quebec joins the programme, and thus flies squarely in the face of the Canadian constitution, or else we do not join up and thus deprive our people of a lot of money to which they have the right. What does one do in a case like this? Don't we have to be realistic and make the best of the situation, that is, sign the agreement with Ottawa, counting on its being the last time?" (Taylor, 1987: 392)

The first, shifting of the matching cost-sharing grants for hospital and medical care to a block-funding formula under the Establish Programs Financing (EPF) arrangements in 1977, appeared to have the potential to significantly shift the path of development of public health insurance in Canada. However, the resulting context in which federal principles were seen to be eroding in conjunction with the serious challenge to the integrity of the Canadian state posed by the political success of the sovereignty movement in Québec would result in the *Canada Health Act, 1984* (CHA). The latter was designed to reinforce (and tighten up) the standards governing federal transfers to the provinces for health. This legislation would significantly reinforce the existing system of universal, first-dollar public health insurance in coverage and set the stage for the development of public health insurance's iconic status in Canada.

### **Financing Canadian Health Insurance – Established Programs Financing (EPF)**

Cost-sharing programs posed a serious difficulty from the federal perspective – the federal government retained no measure of direct control over its own costs for these programs. As a response, in 1976, the federal government replaced the matching cost-sharing arrangements for hospital and medical care insurance as well as for post-secondary education with block transfers (both tax points and cash).<sup>31</sup> At least in the short-term, these arrangements seemed to satisfy both the federal and provincial governments. The shift to EPF brought stability to federal expenditures. For their part, provinces were now more exposed to the risk of costs above increases in GDP but, at the same time, these new arrangements provided them with greater flexibility in determining how to allocate health care expenditures. No sooner had these changes come into force than concerns about the ability of the federal government to maintain the national

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<sup>31</sup> The federal government proposed to transfer 12.5 percentage points of personal income tax (13.5 was the final settlement) and one percentage point of corporate income tax by providing “tax room” (e.g. lowering federal taxes) which the provincial governments could then occupy by commensurately increasing their own tax rates. The amount of tax room offered was calculated to approximate one-half of the current federal contribution for the three programs and the remainder would continue to be provided in cash. As the value of tax points vary from province to province depending on the strength of the provincial tax base, these tax points would be equalized to the national average. Secondly, the cash component included an escalator tied to per capita GNP.

principles attached to hospital and medical care insurance was brought into question. As argued below, this would become especially problematic in a context in which the politics of territorial integration were to become highly charged.

By the late 1970s, the federal government was increasingly facing charges that it was allowing the national principles underpinning hospital and medical care insurance to erode. Of central concern was the issue of extra-billing by which various provinces such as Alberta and Ontario were allowing physicians to charge patients fees over and above those received under the provincial insurance plan. These practices were generating considerable public concern.<sup>32</sup> The federal government struck a commission headed by Justice Emmett Hall (who had headed the royal commission in the early 1960s which initially proposed universal comprehensive health insurance.) The terms of reference for the Hall Commission were two-fold: it was to determine whether federal funds were being diverted to non-health purposes and, secondly, whether extra-billing and user fees were contravening the principle of “reasonable access.” (Taylor, 1990: 159) On the first question, the finding was that provinces were not diverting federal funds. On the second question, the Commission report was adamant that user charges were posing serious impediments to reasonable access.<sup>33</sup>

### **Enforcing a National Program – The Canada Health Act (1984)**

In apparent response to these concerns, the federal government adopted the *Canada Health Act, 1984* (CHA). The CHA replaced legislation for the existing programs of hospital insurance and medical care insurance as well as restated, clarified, and tightened up the conditions of the two existing programs. The Act also provided for automatic withholding of federal funds on a dollar-for-dollar basis collected in a province through extra-billing and user fees.<sup>34</sup>

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<sup>32</sup> As Taylor notes “[t]he media had been focusing on the issue, of course, since mid-1978. So heated became the issue that, that three public inquiries were launched, the first in 1979.” (Taylor, 1990: 158)

<sup>33</sup> In Alberta, 43 percent of all doctors were estimated to be extra-billing as of 1983.

<sup>34</sup> While the Act allowed for provincial collection of premiums for the public plan, access to services could not be restricted on the basis of unpaid premiums. (Guest, 1997: 212)

The provinces faced the difficult choice of whether to allow their physicians to extra-bill and incur the penalty in terms of reduced federal transfers or be forced into a confrontation with the medical profession. The pressure on provincial governments was increased as a result of the fact that strong majorities (around 80 percent) of Canadians opposed extra-billing and user fees. (Guest, 1997: 211) Despite some provincial protestation, especially from Alberta, British Columbia and Ontario, no province could politically afford to allow extra-billing -- revealing just how powerful federal conditionality could be in operation.<sup>35</sup> The ban on extra-billing met serious opposition from organized medicine. In some cases, such as Alberta, the government fervently defended the right of providers to extra-bill and only banned the practice under duress. In other cases, serious confrontations developed between provincial governments and the medical profession. Conflict was most serious in the case of Ontario where provincial compliance with the federal legislation precipitated the third provincial doctors' strike in Canada in a twenty-five year period. Although it was clear well before the strike that the government would be able to garner almost unanimous legislative support to legislate doctors back to work, the OMA itself aborted the strike after twenty-five days acknowledging its own "failure to reach the public." (Taylor, 1990: 175)

Public health insurance in Canada continued to be caught up in the territorial politics of the Canadian federation – dynamics which were particularly powerful in the period surrounding the 1980 referendum in Québec on sovereignty-association. While extra-billing was increasingly a problem in the various provinces, it became particularly problematic for the federal government in the context of the Québec referendum. As outlined earlier, in contrast to most other provinces, extra-billing had been banned in Québec from the inception of the Québec program. Thus, the restrictions in the CHA which were the central cause of friction with the provinces, did not, in fact, constitute a constraint on the operation of the Québec program.

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<sup>35</sup> As Guest notes: "Only three provinces, Newfoundland, Prince Edward Island, and Nova Scotia, had eliminated extra-billing and hospital user charges by 30 June 1984. The remaining seven began incurring penalties estimated at \$9.5 million a month in July 1984, but before the three years had elapsed, all provinces and territories had ended extra-billing." (Guest, 1997: 212)

The focus given to the issue of extra-billing and user fees impeding reasonable access to services in various English Canadian provinces was particularly awkward for the federal government. One of the primary federal strategies in the Québec referendum was to argue that continued federal involvement was required to maintain the standards of social programs in Québec. As the leader of NDP at the time, Ed Broadbent, would later note: “In the 1980 referendum, Prime Minister Pierre Trudeau could honestly point to Ottawa as the source and guarantor of popular programs like unemployment insurance, health care and pensions.”<sup>36</sup> During the referendum debate, federal ministers would argue that “a sovereign Quebec would not be able to sustain the social programs that Quebecers enjoyed as citizens of Canada.”<sup>37</sup> (Banting, 1995: 287) However, the federal government could hardly claim responsibility for the standards of health insurance provision in Québec when they were demonstrably higher than those enforced by the federal government.

The accommodating, if self-serving, approach which had guided federal health care funding reforms in the mid-1970s was replaced by a new, more forceful approach when the Liberals, having been replaced by a Conservative minority government in 1979, again formed the government in February 1980. Coincidentally, the Québec referendum was set for May 1980. During the federal election campaign of 1980, which also had important implications for the playing out of the ‘Non’ campaign in the Québec referendum, the former federal Minister of Health, Monique Bégin vigorously attacked extra-billing and user fees and promised to end both practices if elected. (Taylor, 1990: 167) Immediately upon her reappointment as Minister of Health following the Liberal success in the 1980 election, senior departmental officials immediately began preparing a strategy to deal with this problem.

Thus, the Canada Health Act had its genesis, not only in the Hall report of 1979 but also in federal involvement in the Québec referendum campaign. The federal government’s decision to move to EPF in 1976, which has been described as “the most massive transfer of revenues (and therefore substance of power) from the federal to the

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<sup>36</sup> Ed Broadbent, 1998. <http://www.sfu.ca/mediapr/sfnews/1998/Jan22/quebec.html>.

<sup>37</sup> In addition, the federal minister of National Health and Welfare “pointed to the interregional transfers implicit in federal social programs that would disappear...” (Banting, 1995: 287)

provincial governments in Canadian history,” not only failed to stem separatist sentiment in Québec but, by 1980, represented a significant political liability. (Taylor, 1990: 166) In the wake of the failed referendum, the federal government seized the opportunity to reverse the developments precipitated by the move to EPF and shore up its position vis-à-vis the provinces with the CHA which, to the medical profession and provincial governments, represented “an unwarranted, powerful and, for the provincial governments, politically hazardous federal intrusion into a field of provincial jurisdiction.” (Taylor, 1990: 166) The move would set the stage for the rise of health care rise to iconic status in Canada.

## CONCLUSION

The development of a federal program for universal medical care insurance was not a simple linear progression from earlier policy developments. Certainly, earlier policy developments largely ruled out some possibilities for reform and made other options more likely. However, a wide range of options remained open. Instead of resulting from strong positive feedback mechanisms, public medical care insurance emerged in spite of significant negative feedback mechanisms largely triggered by the development of medical care insurance in Saskatchewan.

Rather than being shaped primarily by positive feedback mechanisms, the development of medical care insurance was highly dependent on dynamics resulting from the conjuncture of the politics of health care reform with the politics of territorial integration. The negative feedback mechanisms generated by developments in Saskatchewan were overcome as senior federal policymakers saw an opportunity to fashion a national system of medical care insurance as a mechanism of territorial integration. These same territorial dynamics would be critical in the consolidation and entrenchment of universal, first-dollar health care coverage in Canada nearly two decades later.

Finally, while ensuring the successful passage of a federal program, the successful outcome which did emerge was deeply marked by the sequence of events. For example, the fact that public medical care insurance had already been successfully implemented in Saskatchewan when federal reforms were undertaken largely ensured that the federal

initiative would be a shared-cost (as opposed to straight federal) program. Furthermore, the fact that Québec had tackled the issue of extra-billing at the inception of its program in the late 1960s significantly increased the pressure for the federal government to firmly address the issue of extra-billing and user-fees in the early 1980s.

Explanations which understand the development of universal public hospital and medical care insurance as a reflection of a distinctive Canadian political culture have been largely displaced by new interpretations which place causal primacy on the role of political institutions – especially dynamics generated by the Canadian system of federalism and parliamentary government. These new interpretations have served as an important corrective to earlier interpretations which did not adequately consider either the constraints or potentially transformative dynamics of political institutions. However, at the same time, the latter have tended to pay inadequate attention to the broader contours of the historical period in which reforms took place. In understanding the adoption and consolidation of public medical care insurance in Canada, it is crucial to consider the interaction between the politics of territorial integration and the political context resulting from Canada's specific institutional configuration as well as existing policy legacies. The politics of public medical care insurance, from its inception in the 1960s to its consolidation in the 1980s, did not simply reflect Canada's institutional structure – they were inexorably entangled with broad, powerful forces deeply rooted in the structure of Canadian society.

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**Table 1: Provincial Adoption of Medicare-Eligible Physician-Care Insurance**

<b>Province</b>	<b>Date</b>
Saskatchewan, British Columbia	1968
Newfoundland, Nova Scotia, Manitoba, Alberta, Ontario	1969
Quebec, PEI	1970
New Brunswick	1971

Source: Taylor, 1990: 149.

**Table 2: Support for Medicare, January 1968**

	National	Québec	Ontario	West
Federal gov't should bring in Medicare as promised	55%	64%	49%	55%
Medicare should be postponed	19%	20%	19%	19%
Medicare should be dropped	19%	12%	23%	19%
Can't say	7%	4%	9%	7%

Source: Taylor, 1987: 391.